

For Delta Dental internal use only

Group/Employer number: _____

Coverage type code: _____

Effective date: _____

Dual-Choice Enrollment FormGroup
Name:Group/Division
number:**For PMI internal use only**

Group/Employer number: _____

ID number: _____

Effective date: _____

Please select ONE of the following dental plans:



Delta Dental of California

Dental fee-for-service plan

OR

Dental HMO plan

You must select a network dentist for this plan

Dental office name: _____

Office number: _____

Date Employed:

____ / ____ / ____

Employee Classification:

☐ Full-time☐ Part-time☐ Salaried☐ Hourly☐ Certificated☐ Classified☐ Retired☐ COBRA**Primary Enrollee Information:**

Name: _____

Address: _____

City, state & ZIP: _____

Home phone number: (____) _____

E-mail address: _____

Date of birth: ____ / ____ / ____

☐ Male ☐ Female

Social security number: _____

Action Requested:☐ New enrollment☐ Add dependent☐ Remove dependent☐ Name change☐ Address change☐ Social security
number correction☐ COBRA enrollment☐ **COBRA Enrollment Only***I understand that I may be required by the employer to pay for COBRA benefits.*

Note: If dependent is enrolling under own social security number (SSN), the original enrollee's social security number must be supplied.

Primary enrollee's SSN: _____

Qualifying date: _____

Qualifying reason: _____

Marital Status:☐ Single☐ Married☐ Domestic☐ Divorced☐ Separated☐ Partnership

Do you have dependent children?

☐ Yes ☐ No

Does your spouse have a dental plan?

☐ Yes ☐ No

Who is covered by spouse?

☐ Yourself☐ Spouse☐ Dependent
children

If Delta Dental, indicate group number: _____

Dependent information:**Spouse/Domestic Partner:**

Name (Last, First, MI)

Spouse's SSN

Date of birth

Marriage/Divorce date

M

F

Child(ren):

Name (Last, First, MI)

Child's SSN

Date of birth

If 19 or older, indicate:
Full-time student

Disabled

M

F

For PMI enrollees only:

Code*

Dental office name (if different)

Dental office number

Code*

Dental office name (if different)

Dental office number

*Relationship Codes: Spouse – SP Domestic Partner – DP Child – CH Child of DP – CD Other Adult – OA Other Child – OC

*I understand that I may be required by the employer to pay for these benefits and those for my dependents. I agree to continue membership in the program selected above during employment and while the program is in force and I agree to comply with the terms of the group contract.***Enrollee Signature:** _____ **Date:** _____